

turbance was found very frequently; objective anomalies in 56 cases. In 137 cases the gait showed some disturbance, spastic paresis in 37 cases. The sensory disturbances were found seldom, only in 19 cases. In 163 cases the knee-jerks were markedly increased. Foot clonus 123 times. These are only some of the clinical data which this carefully analyzed material shows.

4. *Fatigue Phenomena*.—Should be consulted in original.

5. *Ménière Symptom-Complex*.—This paper is a review of the large material which the author has used in the preparation of his well-known monograph on the subject of the Ménière complex. The material consists of 208 cases, all of which were examined by a competent otologist. The cases have been collected since 1886, so that a revision would give valuable data in respect to prognosis and to the length of time the disease exists. The number of cases in which such information could be obtained is 80. The classification adopted by the author forms a sufficiently interesting part of his paper to be fully given. Definition: Ménière's Symptom-Complex is a clinical picture consisting of disturbance in hearing and the accompanying trias, tinnitus, vertigo and vomiting, and is often accompanied by headache, cerebellar ataxia, nystagmus, and in rare cases diarrhoea.

I. The condition is found in patients with intact organs of hearing. (1) The apoplectic form (real Ménière's disease of many authors, apoplectic deafness). Anatomical foundation: Hemorrhage into the labyrinth. Infiltration of the acusticus. This happens (a) in cases of normal organs of hearing and in otherwise healthy individuals; (b) in normal organs of hearing, but in people otherwise sick (leucemia nephritis, lues and also in tabes); (2) certain traumatic forms in which the trias followed immediately after the insult (severe concussion, caisson disease, strong detonation).

II. The symptoms occur in ears, the subject of former diseased conditions of acute or chronic character; (a) middle ear diseases; (b) labyrinthine process; (c) processes in outer ear; (d) vertigo symptom in acute and chronic diseases of the acoustic nerve.

III. A result of treatment to the external ear (injections into the ear, catheterization, etc.).

IV. Pseudo-Ménière attacks. Cases are given to illustrate these various conditions, and the points brought out, especially in the way of differential diagnosis, form a valuable contribution to the literature on this subject. SCHWAB (St. Louis).

MISCELLANY

RECURRENT OCULOMOTOR PALSY, WITH A REPORT OF A CASE. William G. Spiller and William Campbell Posey (The American Journal of Medical Sciences, April, 1905).

The patient, a physician, aged 31 years, complained chiefly of diplopia and drooping of right eyelid. On examination there was found to be an almost complete ptosis of the right upper eyelid, and also a paresis of the internal rectus and inferior oblique muscles of the same eye. The left eye was normal, and the pupil of each eye responded normally to light and in accommodation. His

family history was negative, except that one sister had attacks of migraine. When the patient was 14 years old he began to have spells of dimness of vision, with flashes of light, and associated with headache, nausea and vomiting. After two years the spectra disappeared, although the attacks of headache and nausea persisted. In January of 1904 he had an attack of pain in the right eye, followed by diplopia, but with no ptosis, from which he recovered completely in about two weeks. Seven months later he had a similar attack, associated with ptosis, at first intermittent, but later permanent and almost complete. This condition lasted almost five months, when the lid raised for a week and then began partially to droop, in which condition it still remains. A complete examination by Dr. Spiller revealed no sign of other disease of the nervous system, such as tabes or paresis, so that the case must be regarded as one of those rare instances of recurrent oculomotor palsy described by Möbius and others. It however differs from those described by Möbius in being only a partial palsy and limited to the external muscles or the eye, and also in the age of the patient, Möbius fixing 25 years as the arbitrary limit in which this symptom-complex occurs.

C. D. CAMP.

EXPERIMENTAL EPILEPSY. Zimmern and Dimier (*Arch. d'Elect. Med.*, Oct. 10, 1904).

The authors have shown that intermittent electric currents of low frequency applied to the anterior part of the skull in certain animals can produce most of the symptoms of epilepsy. A gradual increase of the current induces coma, which is maintained as long as the current remains of uniform density. With any irregularity of the current motor phenomena intervene, convulsive movements, as of Jacksonian epilepsy with glottic spasm in the earlier stage, and rise of temperature in the later. With the positive pole the coma is less deep than with the negative. A repetition of the experiment enables the coma to be produced by a much weaker current than in the first instance. A very slight increase of the current beyond that required to produce coma brings about death from paralysis of the respiratory center. It is also observed that death may follow a pulmonary engorgement with extravasation of blood into the respiratory passages and a profuse secretion of mucus.

JELLIFFE.

PSYCHIC TRAUMA AND PROGRESSIVE PARALYSIS. H. Kriege (*Zeitschrift f. klinische Medizin*, LV Naunyn Festschrift).

Kriege describes a case and cites two others from literature in which a severe fright apparently occasioned progressive paralysis. He is sure that vasomotor disturbances may result from intense fright as serious as those from physical concussion of the brain. Syphilis and an inherited predisposition are not excluded in his case.

JELLIFFE.

JUVENILE TABES. Giannelli (*Riforma Medica*, Feb. 25, 1905).

Giannelli reports an interesting case of tabes in a virgin of 17 years who was fairly healthy, with no signs of inherited or acquired syphilis. She went in sea-bathing while menstruating, an experience attended by what she describes as "an intense emotion," and for several days thereafter suffered from pain in her joints. These pains gradually disappeared, however, but after a lapse of three months she had pains of the lancinating type, with severe unilateral headache. These recurred more and more often, and at 22 she displays the typical syndrome of juvenile tabes. The author gives a brief summary of the literature, and calls attention to the fact that a number of cases so recorded belong in the class of Freidreich's ataxia. Some come from a symptom-complex resulting from a specific meningitis, and but few appear as the typical picture of pure tabes.

JELLIFFE.